January 12, 2015

Mr. J.P. Wieske
Chair, Network Adequacy Model Review Subgroup
c/o National Association of Insurance Commissioners
444 North Capitol Street, N.W., Suite 701
Washington, D.C. 20002
Attention: Jolie H. Matthews, Esq.

Submitted electronically to jmatthews@naic.org

Re: Comments on the NAIC Managed Care Plan Network Adequacy Model Act

Dear Mr. Wieske:

On behalf of the members of the American Podiatric Medical Association, Inc. (APMA), the national organization representing the vast majority of America’s foot and ankle physicians and surgeons, I welcome the opportunity to provide comments to the National Association of Insurance Commissioners’ (NAIC) Network Adequacy Model Review Subgroup regarding updates to the Managed Care Plan Network Adequacy Model Act (Model).

APMA believes that regulation of network adequacy is key to ensuring that consumers have appropriate access to necessary health care services. Such access prevents the types of delays that result in unnecessary morbidity and, with regard to foot and ankle health, ensures that covered individuals remain mobile and are able to get the exercise necessary to maintain good health.

APMA appreciates the approach that the NAIC has taken in strengthening its model law. We have the following comments on the Model and changes that NAIC has already made:

Section 5.B. – Adoption of Quantitative Requirements

APMA believes that rather than allowing health plans to adopt “any reasonable criteria,” the Model should require each state to take the approach discussed in the NAIC note for this section by adopting specific, quantitative criteria. Such an approach lends to the creation of software that effectively measures a plan network against the adopted quantitative requirements, enabling regulators and plans to easily evaluate network adequacy. This approach has proven effective in the Medicare Advantage program, under which plans can easily determine, using online tools and software, where network deficiencies exist and regulators can easily determine whether the quantitative standards have been met. This approach also guarantees all consumers within a state a minimum level of accessibility to network providers.
In addition to the criteria noted in the model, this quantitative data should also take into account:

- Number of physicians accepting new patients;
- Time and distance to access providers;
- Hours a week that physicians/providers are available; and
- Privileges at network hospitals.

Finally, APMA notes that both regulators and health plans should take into consideration consumer complaints in determining whether a network is adequate to meet consumer needs and the intervals in which such network should be measured for compliance with the quantitative standards.

**Section 6.F. – Transparency and Use of Quality Factors in Participation Decisions**

APMA appreciates that NAIC has included a requirement under section 6.F that carriers must use quality measures as part of their criteria for network inclusion or tiering decisions. APMA believes that cost efficiency measures, such as utilization, referral rates and price, should only be used in conjunction with quality measures. APMA is concerned about carriers’ practice of determining physicians’ qualifications to participate in networks based on utilization of health care services and lower cost of care without regard to the appropriateness of the care furnished. Such an approach does not assess the quality of care provided by the physician, measure the physician’s conformance with the applicable standards of care, or identify physicians with good outcomes of care. Consequently, carriers that only utilize such measures as participation criteria do not ensure that their members receive the highest quality of care, inappropriately interfere with the relationships between physicians and their patients, and provide incentives for physicians to underutilize care and under-treat their patients.

APMA believes that any time utilization of health care services is used as a factor in a network participation decision, it must be measured in a way that reflects whether appropriate care was furnished and identifies under-utilization as well as over-utilization. Measures of appropriateness of care can only be made based on well-recognized and accepted standards of care and must give full consideration to the risk status of patients on the physician’s panel.

Thus, APMA believes that the change in section 6F is a step in the right direction to ensure that consumers have access to quality care. However, this section does not address the weight that quality measures should have in determining participation status. APMA suggests that NAIC require transparency with regard to participation criteria so that consumers better understand network/tiering inclusion criteria. APMA recommends that NAIC require that if a carrier uses combined cost/quality criteria, it must disclose the relative weights of cost (including utilization) and quality used in determining the score. Such an approach allows consumers to better evaluate and understand the value of the network plan that they are purchasing.
Section 6.F.5. – Non-Discrimination and Access to all Types of Licensed/Certified Providers

APMA supports the change made in this section to remove the reference to “types of providers.” This change is consistent with Section 2706 of the Affordable Care Act (ACA), 42 U.S.C. 300gg-5(a), which prohibits discrimination with respect to participation or coverage against health care providers acting within the scope of their licensure or certification. APMA believes that enforcement of this provision is necessary to ensuring that consumers have access to the full range of physicians licensed or certified to address their health care needs. APMA notes that few states have adopted regulations to implement Section 2706. APMA recommends that NAIC include in the model a new section U under section 6.F.5. to remind health carriers of their obligations under Section 2706 of the ACA and to ensure that regulators enforce these obligations as they appear in contracts between carriers and physicians. Such a provision would state:

   “U. A contract between a health carrier and a provider shall not contain provisions or other terms that conflict with the carrier’s obligations set forth in 42 U.S.C. 300gg-5(a), which prohibits discrimination with respect to participation or coverage against health care providers acting within the scope of their licensure or certification.”

Thank you for the opportunity to provide comments, and we hope the above information is helpful. If you have any questions regarding our comment letter or require more information from us, please contact Scott Haag, JD, MSPH, Director of APMA’s Center for Professional Advocacy and Health Policy & Practice department, at by phone at 301-581-9233 or via e-mail at slhaag@apma.org.

Respectfully,

Frank Spinosa, DPM
President